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Ethics policies on euthanasia in hospitals—A survey in Flanders (Belgium)

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Abstract

Objective: To determine the prevalence, development, stance, and communication of written institutional ethics policies on euthanasia in Flemish hospitals.
Methods: Cross-sectional mail survey of general directors of all hospitals ($n = 81$) in Flanders, Belgium.
Results: Of the 81 hospitals invited to participate, 71 (88%) completed the questionnaire. Of these, 45 (63%) had a written ethics policy on euthanasia. The Belgian Act on Euthanasia and centrally developed guidelines of professional organisations were the most frequently mentioned reasons for and sources used in developing ethics policies on euthanasia in hospitals. Up to one-third of hospitals reported that they developed the policy upon request from physicians or nurses, or after being confronted with a euthanasia request. Development and approval of institutional ethics policies occurred within a multidisciplinary context involving clinicians, ethicists, and hospital administrators. The majority of hospitals restrictively applied the euthanasia law by introducing palliative procedures in addition to legal due care criteria. Private Catholic hospitals, in particular, were more likely to be restrictive: euthanasia is not permitted or is permitted only in exceptional cases (in accordance with legal due care criteria and additional palliative care procedures). The majority of hospitals took the initiative to communicate the policy to hospital physicians and nurses.
Conclusions: Since the enactment of the Belgian Act on Euthanasia in 2002, the debate on how to deal with euthanasia requests has intensified in Flemish hospitals. The high prevalence of written institutional ethics policies on euthanasia and other medical end-of-life decisions is one possible outcome of this debate.

Keywords: Ethics; Euthanasia; Hospitals; Policy development; Survey

1. Introduction

In 2002, Belgium became the second country after the Netherlands to enact a law on euthanasia. This

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law allows euthanasia only under strict conditions and to be performed only by physicians [1]. Euthanasia-related mortality rates in Belgium and the Netherlands are low, ranging from 0.30 to 1.20% for Belgium and from 1.70 to 2.59% for The Netherlands [2–4]. Although euthanasia rarely occurs, the complexity of the clinical–ethical decision-making processes surrounding euthanasia requests and the need for adequate support and guidance of physicians [5,6] and nurses [7,8] require that healthcare institutions take responsibility for handling euthanasia requests within the institution.

Hence, to develop written institutional ethics policies on euthanasia represents one possible option to guarantee and maintain the quality of care for patients requesting euthanasia. Such a policy might also clarify for caregivers, patients, and their relatives a hospital's stance on handling euthanasia requests. Between January 2004 and December 2005, 54% of all registered cases of euthanasia in Belgium were performed in hospitals [9]. Research about written institutional ethics policies on euthanasia in hospitals has thus far been carried out only in Dutch [10] and in Flemish Catholic hospitals [11], revealing that of surveyed hospitals 69–79% have such policies in place.

Primary research aims of the study are: to determine the prevalence of ethics policy on euthanasia in comparison with other medical end-of-life decisions (MELDs) (1), to describe how policies on euthanasia have been developed (involved parties, reasons to develop or not to develop a policy) (2), to describe hospitals' stance on euthanasia (3), and to describe the communication of these policies (4). Secondary research aim of the study is to describe which hospital characteristics (religious affiliation, size, etc.) influence the prevalence of policies and the stance on euthanasia.

2. Methods

2.1. Study population and data collection

A cross-sectional descriptive mail survey was used. The study was carried out from November 15, 2005 to February 28, 2006, in Flanders, the Dutch-speaking state of Belgium, where 60% (5.9 million) of the nation's population lives. Questionnaires were mailed to the general directors of all hospitals in Flanders ($n = 81$). The list of the Flemish hospitals was obtained from databases of the Flemish Ministry of Health, the list included addresses and institutional characteristics such as type of institution, province, ownership, and size [12]. All non-responders were mailed a reminder together with a new questionnaire 6 and 10 weeks after the first mailing.

2.2. Questionnaire

The 20-item questionnaire was based on the one used in our pilot study [11]. This pilot questionnaire was based on a Dutch semi-structured questionnaire [10] that was adapted to the Belgian context. To optimise the validity of the questionnaire, first a thorough literature review was performed. Second, 12 experts critiqued the relevance and clearness of each item in a standardised way [13]. These experts had broad experience in ethics committees and/or ethics policymaking, or had pertinent knowledge relating to the euthanasia issue. We made small adjustments based on their comments. Lastly, the questionnaire was adapted according to the comments of six general directors to ensure that the questionnaire was clearly written and constructed for the targeted subjects of the study.

The revised questionnaire consisted of 20 questions, organized into five major parts. The first part contained questions about hospital characteristics (type, province, ownership, religious affiliation, size, membership in umbrella organisation). The second part contained on the one hand questions whether and in which year an ethics policy on euthanasia, withholding and/or withdrawing life-sustaining treatment, pain and symptom control with possible death hastening side effects, or palliative sedation has been developed, and contained on the other hand questions about the development of ethics policies on euthanasia (reasons, sources, involved parties). The third part contained questions about the stance on euthanasia for three patient categories (competent terminally ill, incompetent terminally ill, and non-terminally ill patients) described in the policy: euthanasia is permitted according to due care criteria outlined in the law, or euthanasia is permitted only in exceptional cases: according to legal due care criteria and additional palliative care procedures, or euthanasia is not permitted. The fourth part contained questions about the communication of the policy to professional caregivers, patients and rel-

atives. The fifth part contained questions for hospitals without ethics policies on euthanasia (reasons, future plans).

2.3. Definitions

According to Article 2 of the Belgian Euthanasia Act, *euthanasia* is defined as the intentional termination of life by someone other than the person concerned, at the latter's request. 'Someone other' is understood to be a physician and 'terminating life' is interpreted as the administration of a lethal dose of medication [1]. According to the Belgian Euthanasia Act, the physician commits no criminal offence if he fulfils all conditions outlined by law (Art. 3.1.) and if he respects the due care criteria detailed by this act. These conditions and procedures differ when euthanasia is requested by *competent terminally ill patients* (patients in a medically futile condition of constant and unbearable physical or mental suffering that can not be alleviated, resulting from a serious and incurable disorder caused by illness or accident and who will die in the near future) (Art. 3.2), by *incompetent terminally ill patients* via advance directive (patients suffering from a serious and incurable disorder, caused by illness or accident, patients are no longer conscious, and the condition is irreversible given the current state of medical science) (Art. 4.2), or by *non-terminally ill patients* (patients in a medically futile condition of constant and unbearable physical or mental suffering that can not be alleviated, resulting from a serious and incurable disorder caused by illness or accident and who are clearly not to die in the near future (Art. 3.3) [1].

A *written institutional ethics policy* is defined as written agreements (procedures, guidelines, protocols, etc.) authorised at an institutional level to guide caregivers when approaching a clinical–ethical problem that includes a decision-making process and/or phased plan [9].

2.4. Statistics

Data were analysed in terms of percent frequency. Non-parametric measures of correlation were used to calculate associations between categorical variables [14].

For hospital characteristics, Chi Square (χ^2) tests were used to assess whether differences between groups were statistically significant. For 2×2 tables and rxk tables of which at least 20% of cells had expected frequencies less than 5, we used Fisher Exact Test or Chi Square with exact calculation of P-values, respectively. Binary logistic regression analysis was used to analyse which hospital characteristics were independent predictors of having an ethics policy on euthanasia. Multinomial logistic regression analysis was used to analyse which hospital characteristics were independent predictors of the stance in policies on euthanasia. Because the main aim of the study was to describe and to explore, no correction was made for multiple testing. $P < 0.05$ was considered as significant. All analyses were performed using SPSS, release 12.0 [15].

3. Results

3.1. Sample description

The study had an 88% response rate. Of the 81 hospitals invited to participate in our study, directors of 71 completed and returned the questionnaire. The overall composition of the sample corresponded with the population's composition, with the exception of hospital's size: the proportion of large hospitals was lower in the sample in comparison with the population ($\chi^2 = 10.257$, $P < 0.05$) (Table 1).

Seventy-nine percent ($n = 56$) of the participating hospitals were general hospitals that provide acute care, and 21% ($n = 15$) were hospitals that provide specialised care for chronically ill patients. Two-thirds of the hospitals were private and 62% were medium sized (201–600 beds). The majority of the hospitals were members of an umbrella organisation: 58% ($n = 41$) in Caritas Flanders, which assembles Catholic healthcare institutions in Flanders, and 31% ($n = 22$) in VOV (Vereniging van Openbare Verzorgingsinstellingen), which assembles public hospitals in Flanders. All members of Caritas Flanders had a Catholic affiliation (Cramer's $V = 0.955$, $P < 0.001$). Of the private hospitals, 81% were members of Caritas Flanders (Cramer's $V = 0.753$, $P < 0.001$). Of the private hospitals, 85% had a Catholic affiliation ($\chi^2 = 0.703$, $P < 0.001$), and of the medium- and large-sized hospitals, 95 and 100%, respectively, were acute hospitals (Cramer's $V = 0.701$, $P < 0.001$).

Table 1
Baseline characteristics of the study sample compared to the overall population of hospitals[a]

	Responding hospitals ($n = 71$)	Population ($N = 81$)	P-value[b]
Type			0.678
General hospital for acute care	56 (78.9)	65 (80.2)	
Specialised hospital for chronic care	15 (21.1)	16 (19.8)	
Province			0.553
Antwerp	21 (29.6)	25 (30.9)	
Limburg	7 (9.9)	9 (11.1)	
East Flanders	16 (22.5)	17 (21.0)	
Flemish Brabant	8 (11.3)	10 (12.3)	
West Flanders	19 (26.8)	20 (24.7)	
Ownership			0.436
Private	47 (66.2)	53 (65.4)	
Public	24 (33.8)	28 (34.6)	
Size			0.014
Small (< 200 beds)	19 (26.8)	20 (24.7)	
Medium (201–600 beds)	44 (62.0)	48 (59.3)	
Large (> 600 beds)	8 (11.3)	13 (16.0)	
Membership in umbrella organisation			0.631
Caritas Flanders[c]	41 (57.7)	47 (58.0)	
VOV[d]	22 (31.0)	24 (29.6)	
None	8 (11.3)	10 (12.3)	
Religious affiliation			1.000
Catholic	43 (60.6)	49 (60.5)	
Neutral	28 (39.4)	32 (39.5)	

[a] Values are number (percentage).
[b] Chi Square with exact calculation of P-value for differences between responding and non-responding group hospitals.
[c] Umbrella organisation that assembles Catholic healthcare institutions in Flanders.
[d] VOV, Vereniging van Openbare Verzorgingsinstellingen; umbrella organisation that assembles public hospitals in Flanders.

3.2. Prevalence

At the time of the survey, 45 hospitals (63%) had a written ethics policy on euthanasia, and 44 hospitals (62%) had a policy on withholding and/or withdrawing life-sustaining treatment. Fewer hospitals had an ethics policy either on palliative sedation ($n = 19$, 27%) or on pain and symptom control ($n = 10$, 14%). Based on self-reported data of this survey, we measured an increase in prevalence of all written ethics policies on medical end-of-life decisions (MELDs) in Flemish hospitals after 2002 (Fig. 1).

Twenty-four percent ($n = 11$) of hospitals had a single policy on euthanasia, whereas 42% ($n = 19$), 16% ($n = 7$), and 18% ($n = 8$) of hospitals not only had an ethics policy on euthanasia but also had a policy on one, two, or three other categories of MELDs. Large, acute, Catholic hospitals that were members of Caritas Flanders were more likely to have an ethics policy on euthanasia (Table 2). Binary logistic regression analysis yielded no statistically significant relationships between hospital characteristics and the presence of a written ethics policy on euthanasia.

Thirty-seven percent ($n = 26$) of hospitals reported not having an ethics policy on euthanasia. Various reasons were provided for lacking an ethics policy on euthanasia: 50% ($n = 13$) indicated that the Belgian Act on Euthanasia provides adequate direction; 36% ($n = 9$) reported that, in their opinion, euthanasia is the responsibility of physicians; 24% ($n = 6$) had not yet been confronted with euthanasia requests. Of the 26 hospitals without an ethics policy on euthanasia, 5 reported that they were in the process of drafting a policy and 6 reported having plans to do so.

The 15 hospitals without future plans to develop an ethics policy on euthanasia were more likely to

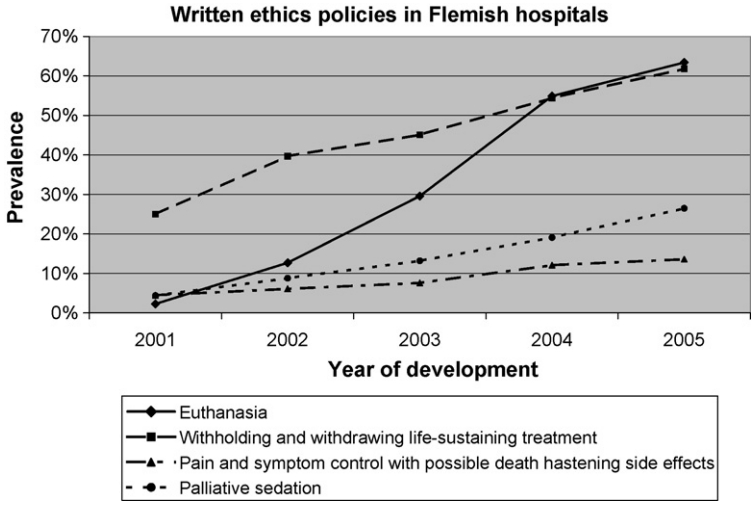

Fig. 1. Prevalence of written ethics policies on euthanasia and other medical end-of-life decisions over time.

Table 2
Association of hospital characteristics with prevalence of ethics policies on euthanasia in Flemish hospitals[a]

	Included hospitals $n=71$	Included hospitals with policy $n=45$	P-value
Type			<0.001
General hospital for acute care	56 (78.9)	43 (76.8)	
Specialised hospital for chronic care	15 (21.1)	2 (13.3)	
Ownership			0.528
Private	47 (66.2)	31 (66.0)	
Public	24 (33.8)	14 (58.3)	
Size			<0.001
Small (<200 beds)	19 (26.8)	5 (26.3)	
Medium (201–600 beds)	44 (62.0)	32 (72.7)	
Large (>600 beds)	8 (11.3)	8 (100.0)	
Membership in umbrella organisation			0.012
Caritas Flanders[b]	41(57.7)	31 (75.6)	
VOV[c]	22 (31.0)	12 (54.5)	
None	8 (11.3)	2 (25.0)	
Religious affiliation			0.017
Catholic	43 (60.6)	32 (74.4)	
Neutral	28 (39.4)	13 (46.4)	

[a] Values are number (percentage) unless stated otherwise.
[b] Umbrella organisation that assembles Catholic healthcare institutions in Flanders.
[c] Umbrella organisation that assembles public hospitals in Flanders.

be specialised hospitals for chronic care ($\chi^2 = 6.667$; $P = 0.046$). Multinomial logistic regression analysis yielded no statistically significant relationships between hospital characteristics and hospitals' future plans to develop ethics policies on euthanasia.

3.3. Development process

Table 3 summarises the factors influencing the development of ethics policies on euthanasia. The approval of the Belgian Act on Euthanasia was the most frequently mentioned reason hospitals developed an ethics policy on euthanasia ($n = 41$, 91%). For Catholic hospitals, distribution of euthanasia guidelines from professional organisations was also frequently reported ($n = 17$, 55%). Several sources were consulted when drafting ethics policies on euthanasia, of which the act on euthanasia ($n = 41$, 91%) and guidelines on euthanasia from professional organisations ($n = 41$, 91%) were the most frequently reported. For policy development, the ethics committee, palliative experts, daily managerial staff, and the medical board were the most involved partners; for policy approval, the ethics committee, the daily managerial staff, the board of directors, and the medical board were most involved. Especially in Catholic hospitals, the board of directors was involved in the approval of the policy ($n = 24$, 77%).

Table 3
Reasons, sources, and partners involved in developing written ethics

	Total $n = 45$	Catholic hospitals $n = 32$	Neutral hospitals $n = 12$	P-value
Reasons for developing ethics policy[a]				
Approval of Act on Euthanasia, 28 May 2002	41 (91.1)	29 (93.5)	12 (85.7)	0.409
Distribution of euthanasia guidelines from professional organisations	17 (37.8)	17 (54.8)	0 (0.0)	<0.001
Upon request of physicians	15 (33.3)	12 (38.7)	3 (21.4)	0.425
Upon request of nurses	13 (28.9)	11 (35.5)	2 (14.3)	0.273
Approval of Act on Palliative Care, 14 June 2002	12 (26.7)	8 (25.8)	4 (28.6)	0.847
Confrontation with euthanasia requests	10 (22.2)	8 (25.8)	2 (13.3)	0.321
Sources used in developing ethics policy[a]				
Act on Euthanasia, 28 May 2002	41 (91.1)	29 (93.5)	12 (85.7)	0.409
Euthanasia guidelines from professional organisations	41 (91.1)	30 (96.8)	11 (78.6)	0.057
Scientific publications	27 (60.0)	21 (67.7)	6 (22.2)	0.116
Policies of other hospitals	25 (55.6)	17 (54.8)	8 (57.1)	0.885
Position papers in newspapers	22 (48.9)	17 (54.8)	5 (22.7)	0.232
Experiences of physicians	19 (42.2)	14 (45.2)	5 (35.7)	0.553
Experiences of nurses	19 (42.2)	14 (45.2)	5 (35.7)	0.553
Partners involved in developing ethics policy[a]				
Ethics committee	44 (97.8)	30 (96.8)	14 (100.0)	0.385
Palliative experts	39 (86.7)	29 (93.5)	10 (71.4)	0.053
Daily managerial staff	20 (44.4)	14 (45.2)	6 (42.9)	0.885
Medical board	17 (37.8)	11 (57.1)	6 (42.9)	0.637
External experts	17 (37.8)	12 (35.5)	5 (35.7	0.848
Board of directors	14 (31.1)	12 (38.7)	2 (14.3)	0.087
Middle management	12 (26.7)	12 (38.7)	0 (0.0)	0.001
Partners involved in approving ethics policy[a]				
Ethics committee	40 (88.9)	27 (87.1)	13 (92.9)	0.555
Daily managerial staff	27 (60.0)	20 (64.5)	7 (50.0)	0.357
Board of directors	27 (60.0)	24 (77.4)	3 (21.4)	<0.001
Medical board	26 (57.8)	17 (54.8)	7 (29.2)	0.763
Palliative experts	20 (44.4)	13 (41.9)	7 (50.0)	0.614
Middle management	7 (15.6)	6 (19.4)	1 (14.3)	0.267

Values are number (percentage).
[a] Multiple responses were possible.

3.4. Stance

Table 4 presents the stances on euthanasia that different hospitals described in their ethics policies. In cases of competent, terminally ill patients, euthanasia was permitted only in exceptional cases (in accordance with legal due care criteria and additional palliative care procedures) in 75% ($n = 33$) of hospitals. In 23% ($n = 10$) of hospitals, euthanasia was permitted in accordance with the law. In one hospital, euthanasia was prohibited, primarily because euthanasia conflicted with the religious identity of the institution and because of the irreversibility of euthanasia.

In cases of incompetent, terminally ill patients, euthanasia was permitted only in exceptional cases in 57% of hospitals ($n = 25$). In 21% ($n = 9$) of hospitals, euthanasia was permitted in accordance with the law. Euthanasia was prohibited in 23% of the hospitals ($n = 10$); frequently mentioned reasons were euthanasia conflicted with the religious identity of the institution and frequent problems with advance directives.

In the case of non-terminally ill patients, euthanasia was permitted only in exceptional cases in 50% of hospitals ($n = 22$). In 18% ($n = 8$) of hospitals, euthanasia was permitted in accordance with the law. Euthanasia was prohibited in 32% of hospitals ($n = 14$); frequently mentioned reasons were euthanasia conflicted with the

Table 4
Stance on euthanasia expressed in written ethics policies on euthanasia ($n = 44$)[a,b]

	Total	Euthanasia not permitted	Euthanasia permitted only in exceptional cases[c]	Euthanasia permitted in accordance with the law	*P*-value
In competent, terminally ill patients[d]					
General	44 (100.0)	1 (2.3)	33 (75.0)	10 (22.7)	
Ownership					0.043
Private	31 (70.5)	1 (3.2)	26 (83.9)	4 (12.9)	
Public	13 (29.5)	0 (0.0)	7 (53.8)	6 (46.2)	
Religious affiliation					0.015
Catholic	32 (72.7)	1 (3.1)	27 (84.4)	4 (12.5)	
Neutral	12 (27.3)	0 (0.0)	6 (50.0)	6 (50.0)	
In incompetent, terminally ill patients[d]					
General	44 (100.0)	10 (22.7)	25 (56.8)	9 (20.5)	
Ownership					0.492
Private	31 (70.5)	8 (25.8)	18 (58.0)	5 (16.1)	
Public	13 (29.5)	2 (15.4)	7 (53.8)	4 (30.8)	
Religious affiliation					0.238
Catholic	32 (72.7)	9 (28.1)	18 (56.3)	5 (15.6)	
Neutral	12 (27.3)	1 (8.3)	7 (58.3)	4 (33.3)	
In non-terminally ill patients[d]					
General	44 (100.0)	14 (31.8)	22 (50.0)	8 (18.2)	
Ownership					0.049
Private	31 (70.5)	12 (38.7)	16 (51.6)	3 (9.7)	
Public	13 (29.5)	2 (15.4)	6 (46.2)	5 (38.5)	
Religious affiliation					0.041
Catholic	32 (72.7)	12 (37.5)	17 (53.1)	3 (9.4)	
Neutral	12 (27.3)	2 (16.6)	5 (41.6)	5 (41.6)	

[a] Values are number (percentage) unless stated otherwise.

[b] One hospital with an ethics policy on euthanasia did not respond to these questions.

[c] Euthanasia is permitted only in *exceptional* cases in accordance with *legal due care criteria* and *additional palliative care procedures*.

[d] *Competent terminally ill patient* = patients are in a medically futile condition of constant and unbearable physical or mental suffering that can not be alleviated, resulting from a serious and incurable disorder caused by illness or accident and who will die in the near future (Art. 3.2); *incompetent terminally ill patients* = (via advance directive) patients that suffer from a serious and incurable disorder, caused by illness or accident, patients are no longer conscious, and the condition is irreversible given the current state of medical science (Art. 4.2); *non-terminally ill patients* = patients are in a medically futile condition of constant and unbearable physical or mental suffering that can not be alleviated, resulting from a serious and incurable disorder caused by illness or accident and who are clearly not to die in the near future (Art. 3.3) [1].

Table 5
Communication of written ethics policies on euthanasia ($n = 44$)[a,b]

	At own initiative	Upon request	No communication
Communication of policy to professional caregivers			
Physicians	40 (90.9)	1 (2.3)	3 (6.8)
Nurses	36 (81.8)	4 (9.1)	4 (9.1)
Other professional caregivers	32 (72.7)	9 (20.5)	3 (6.8)
General practitioners	12 (27.3)	15 (34.1)	17 (38.6)
Communication of policy to patients and relatives			
Patients	3 (6.8)	29 (65.9)	12 (27.3)
Relatives	1 (2.3)	33 (75.0)	10 (22.7)

[a] Values are number (percentage).
[b] One hospital with an ethics policy on euthanasia did not respond to these questions.

religious identity of the institution and the therapeutic possibilities for non-terminally ill patients should be further investigated.

In cases of competent, terminally ill patients and in cases of non-terminally ill patients, private Catholic hospitals were more likely than non-religious, public hospitals to have a more restrictive policy towards euthanasia (i.e., euthanasia is not permitted or is permitted only in exceptional cases).

Because of small numbers of subgroups, multinomial logistic regression analysis for potential relationships between hospital characteristics and hospitals' stance on euthanasia was not possible.

3.5. Communication

The majority of hospitals took the initiative to communicate their ethics policy to physicians ($n = 40$, 91%), nurses ($n = 36$, 82%), other institutional caregivers ($n = 32$, 73%), and to a lesser extent to general practitioners ($n = 12$, 27%) (Table 5). Most frequently used ways of communicating the policy were through informative meetings and by disseminating a copy of the policy. Sixty-six percent ($n = 29$) and 75% ($n = 33$), respectively, communicated the policy to both patients and relatives upon their request. The most common way of communicating the policy to patients and relatives was through a personal conversation.

4. Discussion

In many European countries, an increasing public debate is now going on about the acceptability and regulation of euthanasia and other MELDs [16–21]. In Belgium and the Netherlands, this debate resulted in the legalisation of euthanasia [1,22]. Since the enactment of the Belgian Act on Euthanasia, the debate on how to deal with euthanasia requests within Belgian hospitals has intensified. Indeed, healthcare professionals have become more aware that the complexity of the clinical–ethical decision-making surrounding euthanasia requests goes beyond the individual patient–physician relationship and affects the broader responsibility of the hospital [23]. One result of this debate is the high prevalence (63%) of written ethics policies on euthanasia in Flemish hospitals. Other research about written institutional ethics policies on euthanasia in hospitals has thus far been carried out only in Dutch (in 1994) [10] and in Flemish Catholic hospitals (in 2004) [11], revealing 69–79% have such policies in place.

Over the years, several factors have contributed to the development of written ethics policies in Belgian hospitals. Policy development first began with the drafting of policies dealing with withholding and withdrawing life-sustaining treatment. Since 2002, the development of policies accelerated, growing to encompass policies covering all MELDs. This increased fervour in drafting ethical policies for MELDs might stem from the heightened recognition that prolonging life might not always be the ultimate goal of medicine. Other goals (e.g., improvement of the quality of life of patients and their families by preventing and relieving suffering) that guide clinical decision-making processes at the end of life [3] might have also influenced policy development. By far, the legalisation of euthanasia appears to have greatly

affected the movement to develop ethics policies in Flemish hospitals. Indeed, we found that an increasing number of hospitals developed a policy on euthanasia since the enactment of the euthanasia law in 2002, with the majority of hospitals reporting that the law was both the reason and source for developing a euthanasia policy. A similar trend accounts for the development of do-not-resuscitate (DNR) policies in the USA. After the Patient Self-Determination Act became law in 1991, the prevalence of DNR policies increased significantly in American nursing homes [24,25].

Another factor that may have affected the development of hospital ethics policies is the increasing need of physicians and nurses for guidance on how to deal with euthanasia requests [5–8]. Up to one-third of hospitals reported that they developed a policy upon the request of physicians or nurses, or after being confronted with a euthanasia request. Clinicians (e.g., palliative experts), in addition to hospital administrators and ethics committees, also actively participated in policy development. This indicates that clinicians also acknowledge their responsibility in contributing to ethics policies. The partnership between clinics, ethics, and law is crucial in order to develop an ethics policy with broad framework accommodating decision-making processes on euthanasia [23]. Such a partnership is also necessary to avoid drafting policies that are disconnected from clinical reality [23]. However, 9 and 18% of hospitals did not communicate the policy at own initiative to employed physicians and nurses. One would expect that such a policy is communicated systematically to all relevant staff members.

Notable is the important role of ethics committees both in developing and approving institutional ethics policies. In Belgium, hospitals are required by law to have an ethics committee [27]. Earlier studies found associations between the existence of an ethics committee and the presence of an ethics policy on MELDs, when institutions are not required by law to have an ethics committee [11,28,29]. Through their role, means, and expertise, ethics committees are in a favourable position to carry out and support ethics policy development on an institutional level.

General hospitals for acute care, large hospitals, hospitals that are member of Caritas Flanders and Catholic hospitals are more likely to have an ethics policy on euthanasia. Due to the Flemish context in which all member hospitals of Caritas Flanders are Catholic and large hospitals are more likely to be acute hospitals – as illustrated by the strong statistical correlation between these characteristics – it was impossible to identify hospital characteristics as independent predictors of having an ethics policy on euthanasia. However, Caritas Flanders may have had an important role in stimulating Flemish Catholic hospitals to develop an ethics policy on euthanasia, as shown in the results: 76% of hospitals that were member of Caritas Flanders had a euthanasia policy. Caritas Flanders disseminated the position paper “Caring for a dignified end of life” [30], together with a clinical practice guideline “Facing requests for euthanasia” [31] to all members. In addition, our results revealed that guidelines of professional organisations functioned both as important reasons and sources for developing euthanasia policies in Flemish hospitals. Other studies also showed the influence of professional organisations on policy development [11,26].

Regarding hospitals’ stance on euthanasia, the majority of Flemish hospitals regard the mere application of due care criteria outlined in the law as insufficient to justify euthanasia, especially for incompetent terminally ill (via advance directives) and non-terminally ill patients. Our results showed the likely influence of Caritas Flanders’ stance on euthanasia for competent terminally ill patients: 84% of Catholic hospitals permitted euthanasia only in exceptional cases, after applying additional palliative procedures, in comparison with 50% of hospitals without religious affiliation.

According to Caritas Flanders, euthanasia should be limited to very exceptional cases (states of necessity) of competent terminally ill patients, and not in case of incompetent patients and non-terminally ill patients. Caritas Flanders encouraged to add another condition to the application of the euthanasia law, namely the palliative filter. The palliative filter is an additional requirement to apply palliative care procedures after a euthanasia request has been formulated: the care for a patient requesting euthanasia should include a consultation with a specialized palliative care team in order to consider the real needs of the patient. When using the palliative filter, euthanasia can only be considered as ‘case of necessity’ or as ‘casus perplexus’, consequently, euthanasia is only possible in exceptional cases [30,31].

Euthanasia requests from incompetent terminally ill and non-terminally ill patients encounter even

more resistance from Catholic hospitals. Yet, only 28 and 38% of Catholic hospitals completely prohibited euthanasia for incompetent terminally ill and non-terminally ill patients, respectively, while the majority of Catholic hospitals permitted euthanasia in exceptional cases, after using the palliative filter. In this way, they may be more restrictive than the Belgian Act on Euthanasia on the one hand and more tolerant than Caritas Flanders' stance on euthanasia on the other hand. In contrast, public, neutral or non-religious hospitals were more likely to allow euthanasia in accordance with the law without further restrictions. The obvious influence of religious affiliation on the stance on euthanasia that hospitals take was also seen in our pilot study [11] and in The Netherlands [10].

The present study was the first to investigate written institutional ethics policies on euthanasia in all Flemish hospitals. Several follow-up endeavours resulted in a high response rate of 88%, which is a strength of this descriptive study. The sample composition corresponded with the overall composition of the population. Nevertheless, data were based on self-reports from hospital administrators, which might temper data reliability. On the other hand, the questionnaire was thoroughly validated and queried only facts (not views or beliefs); thus, socially desirable answers may have been curtailed.

However, these results are based on self-report and therefore should be interpreted prudently. Content analysis of policy documents – which has not been performed – would add important information about hospitals' stance on euthanasia in a more thorough manner. Further research is needed to investigate how these policies are implemented in hospitals.

Although this study describes an important evolution in policy development on euthanasia after the approval of the Belgian Euthanasia Act in 2002, additional research is needed to analyse the degree to which ethics policies actually contribute to guiding physicians in dealing with euthanasia requests and to higher quality care for patients requesting euthanasia.

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